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# Reward hospitals for improving quality and publish data on outcomes, Darzi review says

Rebecca Coombes LONDON

Hospitals will be required to publish a range of data on outcomes, from surgeons' death rates and infection levels to patients' ratings of whether staff were compassionate, under changes included this week in the final report of Ara Darzi's review of the NHS in England. These data would in part affect the amount of funding given to healthcare providers.

The long awaited report from the health minister Lord Darzi did not set any new national targets or herald any substantial reorganisation for the NHS but instead emphasised the need to improve quality of care after a decade of investment in services. Lord Darzi said that providers would have to publish quality indicators so that patients could choose where, when, and how to be treated in the NHS.

For the first time, patients' own detailed views on their treatment will be collected and published, alongside more objective measures of safety and clinical outcomes. Data will be available on NHS websites but will also be displayed in hospitals and general practices—for example, information on length of stay and how soon patients are seen.

Lord Darzi said, "The patient experience is the most powerful lever here and will be used for service improvement. The whole report is about quality—it's what energises staff in the NHS. We have done the investment, increased the number of doctors and nurses; we are getting rid of waiting lists [and] now want to improve quality of care."

The health secretary, Alan Johnson, said that the report was about "more clout to patients, more say to patients."

In addition to the payment by results system, funding to hospitals will also depend on quality of care as well as volume. About £7m-9m (£9m-11m; \$14-18m) of an average district general hospital's annual £250m budget will depend on delivering better outcomes, said Mr Johnson. There will also be bonus money for high performing clinical teams. NHS organisations will have to publish "quality accounts" alongside annual financial accounts.

Lord Darzi announced the draft of a new legal NHS constitution, which will reinforce



Health secretary Alan Johnson unveils to parliament details of the long awaited Darzi review

patients' right to choose who treats them and where and what type of treatment. For example, Mr Johnson said that some patients wanted the power to avoid invasive surgery and opt for a keyhole procedure.

However, it emerged that this was not an absolute right. Patients could choose a general practice and GP, but little could be done if that practice's list was full. Similarly, a patient could express a preference for a certain consultant or surgeon, but the choice would not be guaranteed. Furthermore 5000 patients with complex health problems are to pilot personalised budgets.

Lord Darzi's final report was not prescriptive about how services could be reformed, although it said that reorganisations of services—for example, setting up specialists centres for stroke care—must be locally driven. And the report said little new on polyclinics, but a more detailed report on primary care is to be published later this week.

Lord Darzi referred to "change fatigue" among NHS staff. "I understand that NHS staff are tired of upheaval when change is driven top down. It is for this reason I chose to make this review primarily local, led by clinicians."

There was general relief about the lack of prescription in Lord Darzi's report although concern about a lack of detail.

The BMA said it was pleased that the government has stated its intention to move away from "target driven" health policies, but it was concerned about how data on quality would be collected. Hamish Meldrum, the chairman of BMA Council, said, "There is still a long way to go in having access to accurate, reliable, and meaningful data that enables patients, working with their doctors, to make fully informed choices about their treatment."

This was a view echoed by the Healthcare Commission. The chairman, Ian Kennedy, said, "It's important to recognise that it is not easy to define outcomes when you move from surgery to medical care."

Niall Dickson, chief executive of the King's Fund, said that the report was too vague. "There are no estimates of how much all this will cost and no indication of just how different the government expects the quality of health services to be in five or 10 years' time."

The report sets out ways that the government plans to widen choice in primary care, by enabling NHS staff, such as nurses, to set up "social enterprises."

High Quality Care for All is at [www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_085825](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_085825).

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# Government publishes first constitution for English NHS

**Andrew Cole** LONDON

The first ever NHS constitution, enshrining the principles and values of the 60 year old service, will take effect from later this year.

The constitution, thought to be the first of its kind in the world, pulls together existing rights, responsibilities, and pledges in one document. It includes what the government says is a new right—the right for patients to make choices about their NHS care, including choosing their general practice and expressing a preference for using a particular doctor.

The constitution will be reviewed every 10 years and will be accompanied by a handbook that sets out current guidance.

The draft constitution follows year long discussions with staff, patients, and the public. It reaffirms that the NHS is a comprehensive service; that access should be based on clinical need, not an individual's ability to pay; and, with a few exceptions, that the NHS should be free of charge.

The health secretary, Alan Johnson, accepted that the right to choose a GP might be theoretical in some circumstances because “some lists are full.”

Several commentators also thought that the constitution would make little difference on this point.

A spokesman for the BMA said, “At present a patient has a free choice of GP, but clearly there are practical considerations if GPs were to take patients from outside their catchment area. There is a formal procedure for a GP wishing to close his or her list, which has been in place for a while. On the face of it, the constitution would not appear to change present circumstances.”

Iona Heath, a north London GP and chairwoman of the international committee of the Royal College of General Practitioners, expressed scepticism about the constitution. She said, “The draft constitution looks like another example of the emperor's new

## New body will oversee

**Edward Davies** BMJ

All postgraduate medical education in England will come under the supervision of Medical Education England (MEE) from next year.

The creation of the body was one of the key recommendations of John Tooke's inquiry into Modernising Medical Careers and has been wholly adopted by Ara Darzi's review of the NHS

clothes—it's simply an expanded version of the old patients' charter. I can't see anything genuinely new in it at all.

“Patients have always been able to choose their GP. In fact now their choice is less, because they can only register with a practice and not with a named doctor.”

There will also be rights to be treated with dignity and respect and to complaint and redress, allowing the public to get a swift response if they are unhappy with their health care.

The constitution contains a number of pledges in which the NHS promises to “strive” to achieve a range of objectives, including providing services in a safe and clean environment, ensuring smooth transition between services, and sharing any letters sent to clinicians about a patient's care.

Rights are to some extent balanced by responsibilities, including the responsibility to “make a significant contribution to your own and your family's good health and take some personal responsibility for it.”

Steve Field, president of the Royal College of General Practitioners, welcomed the constitution. “It is something to which all GPs, their practice teams, and NHS staff can commit to and have confidence in to improve standards and care for all our patients.”

A final version is to be released by the end of the year.

*Cite this as: BMJ 2008;337:a640*



Lord Darzi watches as prime minister Gordon Brown talks to a patient at a hospital in Leatherhead, Surrey

## GPs face greater competition after Darzi's review

**Adrian O'Dowd** MARGATE

Radical changes are outlined in the Darzi review this week, which leaves GPs facing a very different future.

General practices may find themselves competing with nurse led social enterprise companies to provide services, and some patients

with chronic diseases will be able to hold personal health budgets. Doctors are also going to have to publish “quality accounts,” and work more closely with local authorities.

The quality of service provided in primary care will dictate future funding, as it will in other parts of the NHS, and the report makes it clear that GPs will be scrutinised more closely than ever before to ensure that they provide better and ever improving services.

A “fairer” funding system will be developed, says the report, ensuring that better rewards go to GPs who provide responsive,

accessible, and high quality services. Patients will get a greater choice of general practice and better information to help them choose. Patients will get the information they need to judge services by using the NHS Choices website.

The document reaffirms the provision of more than 150 GP led health centres to supplement existing services, but nowhere in the document is the term “polyclinics” used, and the report emphasises that there is “no national blueprint.”

*Cite this as: BMJ 2008;337:a644*



## postgraduate medical education in England

(*BMJ* 2008;336:61).

The body will be an independent non-departmental advisory board, headed by a doctor chosen by the Appointments Commission. It will “ensure that policy, professional, and service perspectives are integrated in the curricula,” hold a reserved budget for medical education and training, and scrutinise medical

education and commissioning by strategic health authorities (SHAs).

In addition it will have a presence in every strategic health authority “meaning there are 11 MEEs not one to scrutinise SHAs,” said Lord Darzi. See *Newshound in BMJ Careers* (2008;337:2; doi: 10.1136/bmj.a653).

Cite this as: *BMJ* 2008;337:a635

## Review strengthens patients' right to NICE approved drugs

Rebecca Coombes LONDON

Patients in England will have a new legal right to drugs approved by the National Institute for Health and Clinical Excellence (NICE) if a doctor says they are clinically appropriate.

The right, outlined in health minister Ara Darzi's review of the NHS, applies to drugs and treatments recommended by NICE technology appraisals. The findings of technology appraisals, which advise on whether to use a single drug or treatment and in what circumstances, are already mandatory for primary care trusts within three months of being issued.

But the new right doesn't extend to treatments recommended by NICE guidelines, a separate tier of advice from technology appraisals. In 2004, for example, NICE issued guidelines recommending that primary care trusts should offer women three attempts at in vitro fertilisation treatment; last month, however, a survey showed that only nine of England's 151 trusts were doing so ([www.timesonline.co.uk/tol/life\\_and\\_style/health/article4201163.ece](http://www.timesonline.co.uk/tol/life_and_style/health/article4201163.ece)). The enforcement of such guidelines will remain unchanged under Lord Darzi's plans.

NICE will, however, speed up assessments of new drugs so that it will issue the majority of its appraisal guidance on or around the time of a drug's launch. To achieve this, NICE's budget is expected to triple to £90m (£115m; \$180m) over the next four years. An extra £100m a year will fund the cost of primary care trusts implementing technology appraisals across the board.

Joe Collier, former editor of the *Drug and Therapeutics Bulletin*, said that speeded-up appraisals could be a major development for doctors: “If it is the case that all drugs will be looked at at the time of launch and advice given, then that will be a great advantage.

You won't have doctors having to make a decision about a drug without NICE's decision. It gives greater and earlier clarity.”

He said it would also avoid “NICE blight,” whereby doctors hold off prescribing a new drug until it has been approved by NICE, a process that can take up to two years in some cases.

Professor Collier added that patients shouldn't think they will have a legal right to any drug they wanted. “That would be totally inappropriate. The principle is a non-starter. That will be a decision made by doctors, as it always has been.”

Lord Darzi's report also says that patients will be given the right to expect local NHS trusts to decide on funding of other drugs in cases where NICE has yet to issue guidance. If the local primary care trust decides not to fund a drug that a patient and his or her GP think would be right for the patient, the trust will have to explain that decision to them.

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**The acceleration of NICE procedures is likely to make cases like that of Ann Marie Rogers rarer. She won a court case over the refusal of her primary care trust to fund the drug Herceptin, when NICE was in the process of deciding whether the NHS should fund the drug for early breast cancer**

## Annual “quality accounts” will help improve services

Zosia Kmiotowicz LONDON

A complex and wide ranging network of information gathering systems is being developed to support the drive to improve quality across the NHS—the backbone of Ara Darzi's next stage review.

From April 2010 all healthcare providers working for the NHS will be legally obliged to publish “quality accounts” on safety, patients' experience, and clinical outcomes, in the same way that they publish financial accounts.

The accounts will augment the government's agenda on choice by giving patients information—accessible through NHS websites—on all health services in England, to help them decide where to be treated.

“By measuring this quality across the service and publishing that information for the first time, both staff and patients can work together to make better informed choices about their care,” said Lord Darzi.

Hospitals and general practices that perform best will receive extra funding, says the review. The payment by results tariff, by which hospitals are paid for the procedures they carry out, will be adjusted to reflect quality, with those organisations scoring highest on indicators such as rates of infection, clinical outcomes, and patients' satisfaction being paid more. And the quality and outcomes framework (QoF), which rewards GPs for providing a better level of service, will be fine tuned to include indicators of disease prevention and clinical effectiveness.

Work is also planned to develop measures to gauge the quality of care in the English NHS and compare it internationally.

Niall Dickson, chief executive of the think tank the King's Fund, said, “For the first time in a systematic way hospitals and GPs will have to account for the outcomes of the care they provide. This will be a new era in which patients will be able to check on the quality of the services they are being offered, from infection levels to success rates following operations. All this should help us all make more informed choices and put pressure on those providing the care to do better.”

A national set of comparable quality measures or “metrics” will be developed across all services, with the first set ready for use by December 2008 in acute services. Quality metrics for community services will be developed and piloted from next year.

Cite this as: *BMJ* 2008;337:a646

# WHO European region commits to health charter that promises greater accountability



Tallinn, Estonia, where European ministers promised more responsive health services

Tessa Richards *BMJ*

A European health charter was adopted last week by health ministers from the 53 countries of the European region of the World Health Organization, together with the WHO itself, the World Bank, Unicef, the International Organization for Migration, and the Global Fund to Fight AIDS, Tuberculosis, and Malaria.

The formal commitment to the charter was made at the end of a three day conference on health systems, health, and wealth, held in Tallinn, Estonia, on 25-27 June.

The charter enshrines a commitment to strengthen the region's health systems and make them more accountable. It also commits member states to making their health systems more responsive to people's needs, particularly poor and vulnerable people.

The charter is based on three central tenets. Firstly, investing in health systems not only improves health and social wellbeing but also helps boost economic development.

Secondly, it is not acceptable for people to become impoverished by ill health. Globally WHO estimates that 150 million people a

year suffer financial catastrophe as a result of paying for their health care, and 100 million are pushed below the poverty line.

Thirdly, health systems are as much about promoting health, preventing disease, and ensuring health is considered in policies outside the health sector as they are about providing healthcare services.

During three days of discussion many ministers of health and finance, policy makers, and academics emphasised the need to prove that investment in health services is good for the economy, given that expenditure on health is growing faster than the economy in most countries.

Evidence collated on the economic costs of ill health and the association between health and wealth was presented in two reports prepared for the meeting by the European Observatory on Health, The Economic Cost of Ill Health in the European Region and Health Systems, Health, and Wealth: Assessing the Case for Investing in Health Systems ([www.euro.who.int/observatory](http://www.euro.who.int/observatory)).

Both reports draw on a wide range of studies to make the case for supporting investment in health. One recent modelling exercise cited in the second report shows that in many western European countries the welfare gain associated with improvements in life expectancy between 1970 and 2003 amounted to 29-38% of gross domestic product. By contrast, in countries where life expectancy fell between 1990 and 2003, including Georgia, Moldova, and Russia, the effect on gross domestic product was negative.

In the European region, the percentage of government spending devoted to health varies markedly (*BMJ* 2008;336:1390), but Nata Menabde, WHO's deputy regional director

for Europe, underlined that there was no "optimal" size for a health budget.

"What matters is how it is spent," she said. "Health systems must show that they use their money in a prudent and transparent manner."

The same message was put forward by Peter Smith, director of the Centre for Health Economics, York University. He took delegates back to 1858 when Florence Nightingale made a "passionate plea for uniform hospital statistics." Since then governments, he said, had been extremely slow and health professionals reluctant to accept the importance of assessing and publicly reporting performance. When the 2000 WHO report, which ranked countries by the performance of their health systems, was published in 2000, it "created a torrent of debate" (*BMJ* 2000;320:1687).

Acknowledging that reliable and uniform comparative health indices of performance are hard to collect, he and many other speakers emphasised they were essential to improving health outcomes, increasing the quality of care, responding effectively to patients' needs, and identifying and reducing health inequity.

Welcoming the inception of the charter, Margaret Chan, director general of WHO, warned, "Health systems will not gravitate towards increasing equity and efficiency without deliberate policies. [The] Tallinn [charter] pushes a strong and important political message," she said, "and it's a global one."

Background documents for the meeting are at [www.euro.who.int/healthsystems/conference/documents](http://www.euro.who.int/healthsystems/conference/documents).

A webcast of the WHO meeting in Tallinn, including the charter signing ceremony is at [www.euro.who.int/healthsystems2008](http://www.euro.who.int/healthsystems2008).

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## Breast cancer: Black women in US are less likely than white

Roger Dobson *ABERGAVENNY*

Black women in the United States are less likely to survive breast cancer than white women, regardless of the stage at which the cancer is diagnosed, a study has found.

The biggest disparities were in women aged under 40 who were diagnosed as having stage

one or unstaged disease. They were twice as likely to die as white women diagnosed at the same stage (*Journal of Surgical Research* 2008 Jun 23; doi: 10.1016/j.jss.2008.05.020).

Black women were less likely to have had surgical excision of their breast cancer and less likely to have radiation therapy.

"A better understanding of the patient, physician, tumour, and treatment factors contributing to the disparity in survival outcomes between black and white women may lead to interventions that reduce racial disparities in breast cancer survival," say the authors.

"Our analysis, which controlled for several variables associated



Black US women have worse breast cancer outlook





Open heart surgery on high or very high risk patients continues to rise year on year

## Surgeons continue to take on difficult cases despite access to death rates

Adrian O'Dowd MARGATE

Surgeons are taking on more high risk heart operations despite fears that publishing data on survival rates would deter them.

The latest heart surgery survival rates for the United Kingdom have been published by the NHS watchdog, the Healthcare Commission, and show continuing high rates of survival as well as numbers of operations for high risk patients that have risen since figures were first published, for the year 2004-5.

The commission said it was pleased that initial fears that publishing data would deter surgeons from performing as many risky operations had proved unfounded.

The statistics are published on the commission's cardiac website, set up in 2006 when heart surgery became the first specialty to publish information on survival.

The site is a joint project between the commission and the Society for Cardiothoracic Surgery in Great Britain and Ireland.

The website gives information on more

than 35 000 heart operations performed between April 2006 and March 2007 and shows survival rates from 37 units for all heart surgery during this period.

The figures show that survival rates have remained consistently high, with no significant change from the previous year.

The national survival rate for all types of heart operations is 96.6%. This is up by 0.1% from last year's figure of 96.5%.

Between April 2006 and March 2007 there were 20 474 heart bypass operations in the UK. Nationally, 98.3% of patients survived, giving an overall rating of "as expected."

There were 3522 aortic valve replacement operations carried out during this period, with a survival rate of 98%, or "as expected."

The proportion of patients undergoing heart surgery continues to rise, says the Healthcare Commission.

The data are at <http://heartsurgery.healthcarecommission.org.uk>.

Cite this as: *BMJ* 2008;337:a583

## women to survive with the same stage

with survival, demonstrated significantly poorer survival for black women under 65 years of age at all stages of disease within each age group."

The study, which aimed to see whether disparities exist at all stages of breast cancer and in all age groups, used data for two decades in 20 424 black

and 204 506 white women diagnosed as having first primary breast cancer. A total of 56 773 women died, 28 802 (51%) from breast cancer.

The results show that black women were more likely than white women to be diagnosed in the under 40 (10.8% v 5.7%) and the 40-49 (24.6% v

18.9%) age groups, and white women were more likely to be diagnosed in the over 65 group (42.2% v 31.1%)

Black women in all age groups were significantly more likely than white women to be diagnosed at a more advanced stage and to have larger tumours.

Cite this as: *BMJ* 2008;337:a586

## German soap opera made references to branded drugs

Annette Tuffs HEIDELBERG

A dispute has arisen in Germany over accusations of surreptitious advertising of prescription drugs in a television soap opera set in a hospital.

The German Council of Public Relations has accused the makers of the drama of failing to make adequate changes to certain episodes, after they admitted accepting payments in return for mentioning specific products.

The amended programmes were broadcast again recently on regional television channels.

The council says that although drug names have been eradicated or changed to fictional ones, the original storylines were kept, and thus the audience could still identify the products. The television company says that the changes were sufficient.

The popular soap opera, *In All Freundschaft* (*In All Friendship*), is made by a production company owned by the east German television



Storylines from the soap opera *In All Freundschaft* contained references to specific drug products

station MDR, itself part of the association of federal state television stations, ARD, which broadcasts some programmes across the whole of Germany and some regionally. Nationwide broadcasts are often repeated by the regional stations.

The soap opera, which is set in a hospital in Leipzig, Saxony, has been running for 10 years and attracts almost six million viewers in Germany every week.

In 2005 the ARD was hit by a product placement scandal. A journalist proved that various commercial products were placed in several ARD soap operas in return for payments of more than €1m (£0.8m; \$1.6m).

Cite this as: *BMJ* 2008;337:a619

## IN BRIEF

**Cadaver robber sentenced:** The New York state Supreme Court judge John Walsh has sentenced the former dentist Michael Mastromarino, aged 44, to a minimum of 18 years and a maximum of 54 years in prison. Mr Mastromarino pleaded guilty to stealing body parts from funeral homes in New York, New Jersey, and Pennsylvania (*BMJ* 2006;332:507).

**Cirrhosis incidence up 45% in past decade:** At least 7000 new cases of cirrhosis are being diagnosed annually in the United Kingdom, and an estimated 30 000 people have the condition. Between 1992 and 2001 incidence rose 45% and prevalence rose 68%. (*Journal of Hepatology* 2008 Jun 25; doi: 10.1016/j.jhep.2008.05.023).

**Doctor drops appeal against extradition:** Jayant Patel, a US doctor, has dropped his appeal against being extradited to Australia to face 14 charges, including three of manslaughter, from when he was a surgeon in Queensland. A US judge has rejected Dr Patel's application for bail (*BMJ* 2008;336:634).

**Dutch government clarifies screening rules:** The Dutch government has agreed that each request for screening embryos through preimplantation genetic diagnosis must satisfy criteria that include whether an individual patient has a high risk of a serious genetic disorder. This follows a row over the technique's extension to cases of patients who have a risk of hereditary breast cancer. A new national committee will establish guidelines and any further extension of the treatment (*BMJ* 2008;336:1270).

**WHO introduces faster tuberculosis tests:** The World Health Organization is to introduce a rapid test that will enable the diagnosis of multidrug resistant tuberculosis in two days in poor countries—much quicker than the two to three months needed at present. The DNA based test will cost €3.30 (£2.61; \$5.20). It will be introduced in Lesotho, Ethiopia, the Côte d'Ivoire, and the Democratic Republic of Congo.

**Dutch smoking ban excludes pure cannabis:** A smoking ban in enclosed public spaces throughout the Netherlands' cafe, restaurant, and hotel sector came into force this week. However, people will be able to smoke tobacco-free pure cannabis in "coffee shops" and to inhale cannabis through a vaporiser or water pipe.

Cite this as: *BMJ* 2008;337:a625

# Smoking bans lead to reduction in heart attack admissions

Roger Dobson ABERGAVENNY

Bans on smoking substantially reduce hospital admissions for heart attacks, research has shown.

On the first anniversary of the ban on public smoking in England, a report shows that smoke-free laws worldwide reduce admissions by almost one fifth (*Preventive Medicine* 2008 Jun 18; doi: 10.1016/j.ypmed.2008.06.007).

This meta-analysis of published studies shows that the effects were immediate. "The fact that many studies from so many locations around the world provide consistent findings of a substantial drop in acute myocardial infarction associated with the implementation of smoke-free laws increases the confidence that . . . smoke-free policies have immediate and substantial benefits in terms of reducing acute myocardial infarctions," says the author, Stanton Glantz, professor of medicine at the University of California.

The analysis is based on eight studies published since 2004, when the first report of such a drop was reported for the town of Helena, Montana.

The results of the analysis show a pooled estimate of an immediate 19% (95% confidence interval 14% to 24%) reduction to admission rates associated with the laws.

The report says that the fact that the studies from Italy and Ireland showed smaller drops in admissions than in US locations may reflect lower levels of compliance with the law. It says that in Italy and Ireland

implementation of the law was associated with a reduction in levels of secondhand smoke exposure of 64% and 69%, compared with an 84% reduction in the United States.

The analysis does not include two studies for which confidence intervals are not available—a small study of Monroe County, Indiana, which found a significant drop in admissions, and a study of Scotland presented at a conference, which reported a 17% drop but which has not yet been published.

The smoke-free law in England, introduced on 1 July last year to make virtually all enclosed public places and workplaces smoke free, has helped record numbers of smokers to quit and will help prevent an estimated 40 000 deaths in the next 10 years, according to the smoking toolkit study presented at the UK National Smoking Cessation Conference this week.

The decline in smoking prevalence for the nine months before the ban was 1.6% compared with 5.5% in the nine months after. Based on these findings, the researchers estimate that at least 400 000 people quit smoking as a result of the ban.

Robert West, Cancer Research UK's director of tobacco studies, who carried out the study, said, "These figures show the largest fall in the number of smokers on record. I never expected such a dramatic impact and of course there are no guarantees that smoking rates will not climb back up again."

See [www.uknsc.org](http://www.uknsc.org)

Cite this as: *BMJ* 2008;337:a597



SIPA/REX

Rapid falls in rates of myocardial infarction accompany smoking bans

## Bethlem seeks home for collection of art by

Wendy Moore LONDON

A campaign to raise funds to provide a permanent new home for nearly 1000 works of art by psychiatric patients was launched in London this week. The collection, belonging to one of the world's oldest hospitals, includes this painting by William Kurelek (see right).

The Bethlem Museum, in

Beckenham, south London, holds the United Kingdom's only dedicated psychiatric art collection. The archives date back to 1559 from the Royal Bethlem Hospital, the original Bedlam, which was founded in London in 1247. Lack of space in the museum's 30 year old temporary building, in a poorly drained corner of the hospital

site, means that only 45 of the 961 artworks can be displayed.

South London and Maudsley NHS Trust, which runs Bethlem today, has committed £1m (£1.3m; \$2m) towards a new building on the Beckenham site to house the archives.

The paintings can be seen at [www.bethlemheritage.org.uk](http://www.bethlemheritage.org.uk).

Cite this as: *BMJ* 2008;337:a626



## WHO guide on safer surgery will prevent millions of injuries

**Bob Roehr** WASHINGTON, DC

A simple checklist in operating rooms worldwide is expected to prevent millions of injuries associated with surgery and save untold numbers of lives, according to the Safe Surgery Saves Lives campaign launched by the World Health Organization, in Washington, DC, on 25 June.

Major surgery is a growing component of health care, with an estimated 234 million procedures a year, or one for every 25 people. "Few of us who live a long life will do so without surgery," said Atul Gawande, the Harvard Medical School surgeon who organised the campaign.

A review of the literature found a bell curve of best to worst results in every country, with rates of complications varying from 3% to 16% and mortality rates from a fraction of a percent to 10%. Estimates are that seven million patients have substantial complications after operations, and one million die.

In the United States there could be a 10-fold difference in the rate of complications between hospitals in a single state, Dr Gawande said.

He cited the prophylactic use of antibiotics to reduce the risk of acquiring infection during surgery as an example of what could be done to reduce complications.

Dr Gawande said that when Michigan introduced the checklist into their hospitals "their infection rates dropped by two thirds; 1500 lives and \$200m (£100m; €126m) were saved in the first 15 months."

More information and training materials on the campaign are available at [www.who.int/patientsafety/safesurgery/en/index.html](http://www.who.int/patientsafety/safesurgery/en/index.html).

Cite this as: *BMJ* 2008;337:a623



JEWEL SAMAD/AFRGETTY IMAGES

Access to basic sanitation remains the most neglected of the millennium development goals

## Is the food crisis eclipsing the importance of clean water?

**Geoff Watts** LONDON

When the G8 group of developed nations meet on 7 July for the opening day of their 2008 summit in Hokkaido Toyako the international charity Water Aid will be among the many lobbying groups eager to scrutinise the final recommendations.

Created to overcome poverty by enabling more of the world's poorest people to get access to safe water and sanitation, Water Aid sees these two necessities as a neglected component of efforts at improving the lot of people in developing countries. Too often water is taken for granted, says Barbara Frost, the charity's chief executive.

Global water availability remains grim. Roughly a sixth of the world's population—1.1 billion people—still has no access to clean water. In Africa 40 billion working hours are taken up every year in fetching and carrying it. In rural areas of the continent, households spend on average a quarter of their time in this way.

Climate change isn't helping. The unpredictability of weather patterns and fluctuations in local water tables can make it more difficult to identify the best way to help a community. Population increase too is a factor, says Ms Frost. "Some countries are improving the percentage of their coverage. But many are staying still. Most of these are in sub-Saharan Africa."

Even more neglected than water itself is one of its key uses: sanitation. In spite of the

acknowledged link between poor sanitation and the prevalence of diarrhoeal disease, 2.5 billion people have no access to proper toilets.

To mark the first day of the G8 meeting, Water Aid will publish a report, *Tackling the Silent Killer*, which argues the case for paying more attention to sanitation.

"Case studies have shown that increased investment in it makes a huge difference to people's livelihoods and health," says Ms Frost. "But it's not a politically popular subject. That's why we've been putting pressure on the G8 as one of the global political bodies that has the most potential to change investment patterns."

The Water Aid report claims that 40% of the world's population lack access to basic sanitation. This shortfall, it argues, "may be the biggest killer of children under the age of 5, and yet it remains the most neglected of the millennium development goals."

This, the report adds, shows a blind spot in development policy: the failure to recognise sanitation's integral role in reducing poverty.

"Contrary to experience in Europe, North America, and the East Asian development states, policy makers continue to regard lack of sanitation as a symptom of poverty rather than as a major contributing factor," says the report.

*Tackling the Silent Killer* will be available from 7 July at [www.wateraid.org/uk](http://www.wateraid.org/uk).

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## psychiatric patients

